Name:
DOB:
Chart:
Age:
Date:

Advancing Care Information Form

Name as on Insurance card: _____ Date of Birth: _____

Have you fallen in the past 12 months? ___yes ___no

Smoker Status:

Never a smoker ___ **Unknown if ever smoked ___** **Smoker, current status unknown ___**

Current every day smoker ___ **Current some day smoker ___** **Former Smoker** ___ (Start Date____ Quit Date____)

Surescripts Consent

I, _____ , agree that Orthopaedic Associates of North County may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes for the duration of two (2) years.

Signature of Patient, Guardian or Legal Representative _____ Date _____

Over the past 2 weeks, how many days have you been bothered by any of the following problems?

Please "circle" the number in the box to indicate your answer.		Not at all	Several	More than half	Nearly all
1.	Little interest or pleasure in doing things?	0	1	2	3
2	Feeling down, depressed, or hopeless?	0	1	2	3
3.	Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4.	Feeling tired or having little energy?	0	1	2	3
5.	Poor appetite or overeating?	0	1	2	3
6.	Feeling bad about yourself or that you are a failure or have let yourself or your family down?	0	1	2	3
7.	Trouble concentrating on things?	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed or the opposite?	0	1	2	3
9.	Thought that you would be better off dead, or hurting yourself?	0	1	2	3

10. If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

____ not difficult at all ____ somewhat difficult ____ very difficult ____ extremely difficult